EXHIBIT V

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LINCOLN BENEFIT LIFE COMPANY Plaintiff	:	CASE NO. 2:15-cv-06699-TJS
- vs -	:	
BRIAN CHABOREK Defendant	:	
LINCOLN BENEFIT LIFE COMPANY Plaintiff	:	CASE NO. 2:15-cv-06700-TJS
- vs -	:	
BRIAN CHABOREK Defendant	:	
LINCOLN BENEFIT LIFE COMPANY Plaintiff	:	CASE NO. 2:15-cv-06702 TJS
- vs -	:	
ROBERT BOWMAN, et al. Defendant	:	

ORAL DEPOSITION OF VAL MUNCHEZ-VAN DER WAGT, taken before Nancy R. Toner, Registered Professional Reporter, Notary Public, at the offices of Gawthrop Greenwood, 17 East Gay Street, West Chester, Pennsylvania on Thursday, June 16, 2016, commencing at 10:20 a.m.

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(Whereupon, on the record at 10:20 a.m.)

VAL MUNCHEZ-VAN DER WAGT was called as a witness after having been first duly sworn according to law, was examined, and testified as follows:

EXHIBIT:

(Whereupon, LBL-1 was marked for identification prior to the commencement of the deposition.)

-- EXAMINATION --

BY MR. LARKIN:

Q. Ma'am, good morning.

A. Good morning.

Q. My name is Jack Larkin. I represent a number of the beneficiaries in the case who are the defendants, along with Amanda Doherty who is stepping into the room as well. She is also on our team.

This is Xavier Hayden who represents two of the beneficiaries. And that's Chris Amentas who represents the estate.

We all have some questions for you today. Before I jump into them, let me ask you have you

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given a deposition in the past.
A. Yes, I have.
Q. Then you probably know there is no way to stop an attorney from telling you the rules of the deposition no matter how many times you have done it. So I will have to do that now.
Basically we are constrained by the fact that we have a court reporter, which means that I'm going to ask you not to speak over me and I will do the same, just because she can't transcribe accurately when we are speaking over one another.
For the same reason, let me finish my entire question so that she gets everything that I say in response to your answer.
When you are giving a yes or a no, don't just give me a head nod or shake and don't give me a mm-mm or mm-hmm because it's very difficult to get down. Give me full words like yes and no.
And probably the most important rule. My assumption is going to be -- has to be that when I ask a question, if you give me an answer, you understand my question and that your answer is responsive to it.
If you don't quite understand what I'm asking or if you think it needs some clarification,

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please ask me to do so. I will be happy to ask the question in any number of different ways.
Beyond that, this is not an endurance contest. There's obviously a very thick binder. I want to ask you questions about a whole bunch of documents that have been produced. I will say in my defense we got 7 or 8,000 pages to begin with. So I've tried to whittle it down a bunch.
If you need to stop for whatever reason, please answer my questions so that you don't leave in the middle of a question. But as soon as you do, just throw up a hand and let me know that you want to take a break either to get something to eat, to drink, to go to the bathroom, or just to take a walk around. Whatever you need.
Does everything that I have said make sense to you?
A. Yes, it does.
Q. In that case, in the big binder in front of you --
A. Can I add one thing?
Q. Sure. Please.
A. I am getting over a cold so we might have frequent breaks.
Q. That's fine. In the big binder in front

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of you, could you turn to Tab 1.
A. (Witness complies with request.)
Q. This is a Notice of Deposition that I served on your counsel. Have you seen a copy of this document before?
A. Yes, I have.
Q. My understanding is that -- on the second page you will see there's a schedule of topics that I intend to cover in this deposition.
My understanding is that you are prepared to discuss all of them as Lincoln's corporate designee with the one exception that, with respect to claims handling, there may be some questions that you are not able to answer and there's another person who, if we need to go to, we can go to; is that correct?
A. Yes, it is.
Q. In addition, if you go two pages in, there's a second schedule that asks for any notes, reports, memoranda, e-mails, or other documents generated during the claim investigation, and the portion of any underwriting manual, table, training manual, or other document governing or setting forth Lincoln Benefit's underwriting policies that support the effect alleged to have been created by the

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purported material misstatement, omission, or error to the extent not already produced.
I see you don't have any documents with you today. But last night we received about 900 pages of documents. Is it your understanding that all the documents that I'm requesting in Schedule B have already been produced?
A. Yes.
Q. In that case, if you could turn to Tab B in Exhibit 1, this is an e-mail that I received from Mr. Gosselin. You are going to see on a couple of these documents there are highlighted portions. The highlighted portions are purely so that I can direct you to it that much faster.
The note here is there's a specific underwriter who is familiar with the facts of the case who assisted with the preparation of the complaint, and who has provided all of the input on behalf of the company in order to address the underwriting issues raised in discovery.
I assume you wouldn't know if you provided all of the information. But to the best of your ability, does this describe you? Are you that person?
A. What was the caveat? I'm sorry.

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Q. I assume that you wouldn't know if you provided all of the information. How could you? Information could have come from another source.

But does this describe you? Do you think you are that person?

A. Yes.

Q. In that case, if you could then turn back to Tab A, this is the complaint that was filed in one of the several cases. It's Docket No. 6702 which is the $600,000 policy. And we have fallen into the pattern of using this complaint to talk about most of the complaints in the case because it tends to be over-inclusive. It has every claim.

If you could turn to Page 4, I'm looking at Paragraph 28, Subsection A. This is describing a question that was asked of the decedent, Paul Godlewski, whether he had within ten years been diagnosed with or sought treatment or advice for a mental or nervous disorder.

What would qualify as a mental or nervous disorder in answering this question?

A. In relation to this case, a history of anxiety, panic disorder, compulsive disorder, depression.

Q. When you say a history, does that require

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a diagnosis?

A. Yes.

Q. When you say anxiety, I've been anxious in the past. What kind of anxiety are you looking for in order to make it into a mental or nervous disorder?

A. A diagnosis of anxiety by a licensed professional.

Q. Would it be fair to say anxiety disorder?

A. Anxiety or anxiety disorder.

Q. If a doctor tells me, Jack, you look anxious right now, I'm diagnosing you as anxious, that counts as a mental disorder?

A. That's a hypothetical. But if the doctor indicates that his diagnosis is anxiety, then we would take that as a mental disorder.

Q. Does every mental or nervous disorder that is reported result in a change in the premiums?

A. No.

Q. What would you have to do in order to get to a change in the premiums?

A. Well, it depends on the attributes of the disorder, the severity, the frequency, level of treatment, the description, the impact it has on the person's health as observed by the doctor and

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reported.

Q. How would that decision be made internally by Lincoln Benefit?

A. We don't diagnose.

Q. Assuming that you have a diagnosis from a doctor and the doctor had provided you with the facts that you were interested in, what guideline would you look at or what manual would you look at? How would you decide how to rate someone?

A. So we have something called a mortality manual that we refer to and we use the Swiss Re manual. And there are different sections that relate to different disorders.

So we would be looking for the nervous mood disorders, and then we would look to see based on the specifics that are in the medical file where that person falls. And also, any other coincident or co-morbidities.

Q. Is the mortality manual the same thing as the Swiss Re manual?

A. Yes.

Q. Do you also use the Gen Re manual?

A. On occasion. But primarily it's Swiss Re.

Q. Why would you use one over the other?

A. So the Gen Re manual would be used for

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specific situations that come up that are not covered by the Swiss Re manual. I'm sorry. The Gen Re manual would come into play when the Swiss Re manual doesn't cover something.

Q. What if you have a situation that is covered by the Swiss Re manual but the Gen Re manual also covers it? Would you be allowed to exercise your discretion?

A. No.

Q. You always --

A. 99 percent of our decisions come out of the Swiss Re manual.

Q. If you could turn to the next page, Subsection B asks whether the decedent had within five years a checkup, consultation, hospitalization, illness, surgery, or medical or diagnostic test.

Let me start at the most broad. What is the purpose of asking that question?

A. To ascertain any medical consultations, the purpose of that consultation, and the outcome.

Q. My assumption is that hospitalization and illness, a surgery, a medical test, a checkup -- in and of themselves, those things would not change your life rating; is that correct?

A. Could you repeat that?

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Q. Sure. There's a long list of, I'm going to say, items. None of them in and of themselves without more would change your life rating. So for example, right now you are getting over a cold. That's an illness.

A. Mm-hmm.

Q. I'm assuming that a cold would not change your life rating.

A. A cold aside, the purpose of these questions are to ask about factual events that occurred that will allow us to find out about a person's health.

So each individual item that's listed is something that we are interested in. And then subject to the additional details, we would be able to determine whether or not it has an impact.

So if you were to say checkup or consultation, just in and of itself, it's meaningless until we get the balance of the details.

Q. And that's what I was really trying to find out. If there's a hospitalization, now you know there's a hospitalization and your question then becomes, okay, for what.

A. Right. Where, when, what was the diagnosis, et cetera.

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Q. What kinds of things would change your life rating in the event of a hospitalization?

A. They are super numerous. Can you be more specific?

Q. If you had head trauma and you went to the hospital for head trauma, would that change your life rating?

A. It depends on the outcome.

Q. What is the variable there?

A. So you have to be more specific, because a head trauma can be a slight bump or it can be, you know, a brain injury. It can be, you know, a skull fracture or a number of things.

Q. Would a concussion in and of itself without more -- and that's all the information that we have in this case, which is why I'm asking specifically about a concussion which I know is a little vague. Would that automatically change your life rating?

A. Well, it wouldn't impact the life rating, but it would determine whether or not we would provide a policy. So we would need to refer to our manual regarding concussions and head injuries.

So if it's a concussion and there's no residuals, no other problems, we normally wait a

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period of six months to make sure there's no manifestation of disorder. And if everything is fine, then we will issue.

And if the record doesn't reflect that there are any problems, then after a six-month period, then we will consider it a standard issue.

Q. What are the kinds of concussion-related problems that you would not underwrite if you saw?

A. That's a really broad question. Can you be more specific?

Q. I don't know that I can because I'm not really sure what the issues are. You said that if there was a concussion you have a six-month waiting period to see if there were complications or issues that arise from the concussion. Is that correct?

A. Right. So maybe we should refer to the documents that we sent that cover this issue and that way we can look at that.

Q. I would like to mark the transcript here as confidential.

(Whereupon, start of confidential portion of transcript.)

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(Whereupon, end of confidential portion of transcript.)

BY MR. LARKIN:

Q. The next question in the complaint -- going back to Tab A of Subsection 1 of the large binder. The next question is whether the deceased planned to spend more than two weeks outside the United States in the next year.

Is there a listing of countries that you would consult in order to determine whether your plan to be outside of the United States would affect your life rating?

A. Yes.

Q. Where is that listing of countries?

A. That's in the RGA manual.

Q. The RGA manual is Tab 48 in the big binder. How do you rate countries outside the United States?

A. So depending on the destination and the risk of a person, an American -- I shouldn't say an American -- one of our customers going there for an extended period of time, there can be a rating that's attached. In this case there was none.

Q. Why not in this case?

A. Because the destinations that we knew

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of -- and I think it was -- actually, it was Istanbul, Turkey, and Israel that had been past travel, by the way -- they were not ratable.

Q. What does that mean?

A. Ratable meaning that for the purpose of a visit to that country for business, I think, that was being conducted was not a risk factor that we would need to charge extra for.

Q. What about Turks and Caicos?

A. We would not rate for that either.

Q. Is there any country that Paul Godlewski traveled to, to your knowledge, that you would rate for?

A. No.

Q. At Paragraph 33 on the same page --

A. I'm sorry. We're on A?

Q. Yes. Page 5 of Tab A within Exhibit 1.

A. Okay.

Q. This doesn't parse out the individual effect of each of the misrepresentations that are alleged. But there's a blanket claim that had Godlewski provided truthful information, Lincoln Benefit would not have reinstated the policy.

If Turks and Caicos is not ratable, it sounds like that is not a variable in your decision

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to reinstate the policy or not. Is that correct?

A. Am I reading the same thing that you are? You are on Page 5?

Q. Page 5, Paragraph 33.

A. There's a statement that says: Had Godlewski provided truthful information -- and it doesn't say what that information is in this sentence, Lincoln Benefit would not have reinstated the policy.

That's a truthful statement, but it's not related to his travel.

Q. Okay. Is there a reason that his travel was included in the complaint then?

A. Very early on during the early part of this investigation, we were not aware of all the places that he had traveled. But we knew that there were more destinations that we had been aware of and that had been admitted to on the application.

But we knew that it was frequent and -- well, it was frequent.

Q. If you could then turn to Tab 2.

A. Okay. Got it.

Q. This is an authorization for release of health-related information that Paul signed in connection with one of his applications for life

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insurance. Why do you request these from your insureds?

A. So in general, every insurance company requires an authorization from a customer before they can do any investigation. We actually have two authorizations. This is one. And this one relates mainly to medical information where the other one relates to investigations in general.

But this one, the reason that we get it signed -- and we get it signed by every customer up front -- is in case we need to request additional information so that we don't have to go back to the customer and ask them to sign it.

So we just get it as one of the submitted forms that, you know, come automatically with a new business application.

Q. When you say request additional information, you mean from people other than the applicant?

A. Yes.

Q. So health providers, employers, whomever else?

A. Primarily health providers.

Q. You did conduct a medical investigation as part of the underwriting process in this case; is

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that correct?
A. Well, yes, we did. Which case? Is it 318 you're referring to?
Q. Well, let me be a little more broad. For each of the policies that Paul had, did you conduct a medical investigation?
A. Medical is a general term. That includes lab results, vitals, bodily fluids. We do do that as part of our underwriting work up. So that's considered medical, but it's medical that we request.
The other part of that medical would be to obtain medical records from a facility that has them, whether it's an individual physician or a medical center.
Q. Did you request records of a physician with respect to each of Paul's life insurance policies in this case?
A. Only on two.
Q. Only on two? Why those two?
A. It had to do with the face amount that was being applied for. And we have standards for selection. When a face amount reaches a certain level, we will get medical records, just part of a routine work up.

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Q. Now, the search that you performed in advance of issuing the policy as part of the underwriting for those two policies was -- it didn't reveal as much information as the search you conducted as part of the claims process. Otherwise, there wouldn't be a mismatch between the two. So why the difference?
A. What was the question? I'm sorry.
Q. Why is there a difference between the search you performed as part of the underwriting process and the search you performed as part of the claims process?
A. Oh. Because the proposed insured, when he completed his applications and his Part 1 and Part 2 examination, all of the information that we provided, including the inspection interview, focused on one physician, Dr. Cuozzo. I'm not sure if I'm pronouncing that correctly.
But he provided us with very limited information about his health. And it was only post-death that we discovered that there were a cadre of physicians that we were not aware of. There was a lot of medical history that had never been admitted, shared.
So yes, that's what the difference is, is

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what we knew and what we investigated. In fact, the name of the physician that he gave us to go to to validate his medical history had a very narrow slice of his history.
Q. If you could to Tab 3, first off, a large section of the discovery that you have produced is -- it looks to me like it's all in the same font and it looks like it's all part of the same computer program. What is this program?
A. So this is the section of what we would call a status print. A status print is a summary that is printed out after a file has been completed in the underwriting area.
So we call it an underwriting work bench. And it is the computer program that we use -- actually, it's LUS, life underwriting system, where we gather all of our requirements, we post all of our requirements, we diary our work up, we make notes about our evaluation. All of that is in this section.
In addition to that, it also receives electronically a feed from our laboratory that has the lab results. Again, that's bodily fluids, vitals. Motor vehicle report as well. That's all I can think of right now.

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Q. What is an MIB?
A. An MIB is a report that we receive -- well, the MIB is an institution that's located in Massachusetts. What it does is it services the insurance industry with a record of information for a person who has applied for insurance previously and a report has been made about them from another insurance company.
So if we search -- that's the term we use -- the MIB and a person has never applied before, then there will be no record. If they have applied before, as is true in this case, and a brief report was made and it was done by us, then when we search the next time, we are going to get a hit and that hit will show what information is reported. So that's what the MIB does.
Q. I have highlighted the line here that says so many that not enough room to put them all in MIB.
A. Yes.
Q. What does that mean?
A. So at this point in time, the insured had applied for a lot of different policies. And there is a -- actually, is that attached in here, the MIB part of this so we can refer to it? No. I thought it would be good for illustrative purposes.

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So what it is saying is that the number of hits that we received back -- IAI is insurance activity index, which also shows the number of times an insurance company searched the bureau.

There were such a number of them that they were unable to be reflected on status prints.

Q. The LUS document that we have here, it sounds like you're saying it's going to be incomplete; it doesn't include necessarily everything because there was so much information that you were not able to enter everything in.

A. I would have to look at it, because this note and what was listed, when I looked at this case before in the past, I believe there were, like, nine or ten pages. I thought it was kind of complete.

So this note that there's not enough room to put them all in, I would have to see is there a cut off that says, you know, we are missing one or two. Or was there a second sheet that had to be provided, which I think is what happened.

Q. Got it. Could you turn to Tab 4. This is similar. It's a note that's in some kind of a different font that says probably due to so many existing policies, unable to enter any info notes in LUS.

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A. Yes.

Q. What does that mean?

A. So there were multiple policies that were being reviewed at the same time. And the underwriter actually placed her notes not in this file but in the companion file.

My understanding of what may have occurred is that it just kind of ran out of room. She wasn't able to put any more information in there. Like, there were a finite number of characters.

Q. Do you know if the information was entered somewhere else?

A. Yeah. On a companion file. I can't speculate what the number was, but there was another number that was pending at the same time.

Q. Is that one of the policies that's at issue in the cases that we are here for today?

A. I believe so, yes.

Q. If you could turn to Tab 5.

A. Can I just make another note?

Q. Sure. Please.

A. The whole purpose of this note also is because she wanted to write down and reflect what her assessment was since she couldn't put it in the other file. So it should appear here and in the

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other file.

Q. You don't know what companion file that was?

A. We could look it up. I couldn't tell you off the top of my head.

Q. You don't know what the dollar figure or the policy value was or who the beneficiaries were, any other identifying information?

A. It should be in here. I don't know how you have it listed in your books.

Q. I mean, we have many thousands of pages. If I just give you a box full of paper, I don't think you're going to be able to find it.

A. Okay.

Q. Let's look at Tab 5. This is another one that notes keep getting errors on 01T1966318 when trying to add notes, notepad appearing to be full. What's that?

A. It's the same thing. Apparently there was a finite number of notes that could be added into this particular file.

Q. On the last one, you said that there was a companion file that notes were entered into. Do you know about that with respect to this?

A. We could research it now if you would

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like.

Q. Well, I would like, but I don't know how you would do that. I'm asking you. And it sounds to me like you're saying you don't know.

A. I do know, but I don't have it all memorized.

Q. Was there a companion file in this case that the notepad was entered into?

A. Yes, for sure.

Q. Do you know what the companion file was?

A. These documents that you have in front of me are out of context. So the entire record is not attached to the sheet. This is one page out of a status print. So each status print should run about 25 pages; but for this, you only have this document.

Q. Understand, I don't blame you if you don't know. It's not a moral failing or anything. It's just that I can't provide you with all of the documents. If I did, we would spend all seven hours answering my first question.

So it sounds like with the information in front of you, you don't know. Is that correct?

A. I would like to take a look to see if I can find it.

Q. Sure. Please.

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A. Do you have the rest of the documents somewhere?
Q. Not printed out.
MR. GOSSELIN: What is the pending question?
BY MR. LARKIN:
Q. The pending question is: Do you know if the information that was not entered with respect to this note because notepad appears to be full was entered into a companion file?
With respect to Tab 4, you knew the answer. You said yes. With respect to Tab 5, you have said this is out of context, you have not seen the whole 25-page print out.
So it sounds to me like you don't know the answer to the question, which is fine. You're not required to.
A. Well, I do know, but you haven't provided me with the documents.
Q. Is it yes or no?
A. State the question again. Let's start from the beginning. Sorry. It's getting a little --
Q. Okay. In Tab 5, there's a note that says keep getting errors when trying to add notes,

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notepad appears to be full. My question is: Do you know if the notes that they were trying to enter were entered into a companion file?
A. If you provide the rest of the documents, I could tell you that. We can look at that together. But I will tell you that several seconds later, there was a note entered into this file; and that was that this reinstatement was approved.
Q. Why would notepad be full if there was another note that was entered several seconds later?
A. That I don't know the answer to.
Q. Why would the decision to approve be made, it looks like, 13 seconds after this was noted?
A. Because she approved the coverage and put the policy back in force. Maybe she wanted to make a longer note. I have no idea. I can't speculate.
Q. If you could turn to Tab 6, this is a note from April 22 of 2013 that notes that the last labs were done on March 27th of 2012, which was pretty close to a year. Is there any rule about how frequently labs have to be performed or how recently labs have to be performed?
A. We have a guideline. But it's up to the underwriter to determine whether or not they are comfortable with issuing labs result that we have.

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Q. What is the guideline?
A. The guideline is that labs results are usually good for about a year when normal.
Q. What kind of discretion does the underwriter have?
A. Full discretion up to their limit of signature authority.
Q. So they could excuse labs all together if they wanted to?
A. Yes.
Q. Is that written in any policy manual?
A. Yes.
Q. And that's the Lincoln Benefit Life manual, not the Swiss Re manual?
A. That is correct. It's the life underwriting policy.
Q. If you could turn to Tab 7, this is, again, the same kind of a note. The labs were performed over a year but close enough. The EKG was done close enough also. So that would be the same answer, I assume, the underwriter was exercising discretion?
A. Yes. We had seen this customer for many years. He was very consistent in the history that he provided. We had evaluated him. We had run

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labs. We had done exams. We were pretty comfortable that we understood his state of health.
So if the underwriter decided to go without an updated lab result or examination, then that was within their discretion.
Q. Are there any policies about allowing an Allstate agent to be the agent broker on their own policy?
A. Are there any policies that allow -- yes. I couldn't tell you what that policy is or how it's written. I didn't memorize that, unless you have it in here.
Q. Well, it hasn't been provided to me.
A. Well, I can tell you that an agent can write an application on himself or herself.
Q. Are there any restrictions on that?
A. Nope.
Q. Is there any preferential treatment that you get?
A. Nope.
Q. If you could turn to Tab 8, there's a bunch of waivers here. Why would an HIV consent alert be waived?
A. So this is all based on system constraint terminology. The fact that it says waived does not

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mean that it was waived. It means that it was removed from being outstanding. So we do have an HIV consent form in the file.

Q. Isn't there a notation that says received?

A. Mm-hmm.

Q. Why would you use waived instead of received?

A. It's a curiosity of the program. The documents will be in the file. We need to keep it out of being in a pending status. We know that we have the document. We just waive it on the system to remove it as being a pending case.

Q. If you put down status received, then that won't do the same thing?

A. Usually those received are electronic receipts. So we have electronic feeds that come in from our Exam 1 company. There are electronic feeds for, like, the lab results, exam form, motor vehicle report, that type of thing.

So when those come into the system, they flick the switch and say received. So those are usually electronic.

Q. So where it says other requirement, financial info, and it's waived, I understand you to be saying that that would be received, in fact? You

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have the financial requirement at that point?

A. No. I didn't say that. I just said sometimes that's why you will see waived instead of received. We do have an inspection interview.

Q. Do you know whether, just looking at this document, would you be able to tell whether something had actually been received or if it had been waived?

A. Sure.

Q. How would you do that?

A. By looking at the balance of the file. But this page is just by itself. It doesn't have the rest.

Q. That's why I asked the question. From looking at this document, would you be able to tell whether you had received the document based on whether it was marked as received or waived?

A. No. But I can tell by looking at the underwriter notes. And I can tell you that I did review the inspection interview. So there is one in the file.

Q. If you can go to 10, here it says age/amount screening bypassed. What does bypassed mean?

A. I would not be able to tell you what that

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means.

Q. What is age/amount screening?

A. So by the way, I could be more exact if we had the entire file. This is, again, just a single page.

Q. I just want to know what age/amount screening means.

A. Oh. So every application that arrives, we have a requirement chart and based on the age of the customer and the amount of insurance they are applying for. So you have a matrix that will decide what minimum requirements we would need to underwrite them.

In his case, he had a number of applications that were being evaluated at the same time. So this possibly could have been that since the requirements were on another case that was pending, that this was bypassed. But I don't know that without looking at the entire document.

Again, this is just -- in fact, I can't even tell what case this comes from because it doesn't have all the other sheets attached.

Q. A lot of my questions, just to be clear, are me trying to figure out what these codes mean. So in some cases I'm going to be asking you about

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specific information about Paul Godlewski. And in other cases, like right now, I literally just want to know what age/amount screening means.

I am not holding you to be responsible for every document with respect to at least that question.

A. I am just saying that I would be able to provide a more thorough and complete answer if we had the entire file for each one.

Q. I understand. You've said that a few times now. I've got close to 9,000 pages. We just can't go through them each time. It would take too long. If you could go to Tab 11.

A. I was just going to say that when we provided them, they were probably all together in a package.

Q. Well, they were not unfortunately. Why don't we go to Tab 11. What is this?

A. So this is a tool that the underwriters use at the end of their underwriting evaluation. We have a method that we use. It's -- sorry -- it's specific to Allstate that allows us to take a look at the person who has -- maybe they have a rating. Maybe they have been assigned some debits because of their history.

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And we can use this tool to pick out those parts of their profile that are very positive and maybe even notice any that are negative and determine whether or not we might be able to provide them a better rating because their overall profile is better than the average person.

So this would allow us to take a person from one rating class -- I should say discount class, not mortality rating class -- to a lower one or a better one.

Q. What is a debit? You just used that term.

A. That's a method that an underwriter uses to identify the increase in mortality.

Q. What does that mean, if you could just unpack that a little bit for me?

A. So if you're looking at -- say we have a continuum. In the center is a standard person. You could have a chart for male and you could have a chart for female. But let's just take a standard person male.

This male could either be a smoker or a nonsmoker. That would be a separate chart. But your standard nonsmoker. Well, if you have positive profile attributes, we are going to give you discounts.

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This is a standard rate which translates into a premium. So we can give you discounts to that because you present a better risk than the average person.

If you have debits, that means that in increments of usually 25 percent, your mortality is higher than the average person. So 25 debits would move you to standard plus 25 debits. And that would reflect in your premium. And that goes on to 50 debits, 75, 100, et cetera.

That's what the debits are. That's it.

Q. In the production, there are probably 50 or so pages like this one. Some of them have information filled out. Others do not. Is there a reason that an agent would leave in the file a healthy credits form like this that had not been completed?

A. This is not completed by an agent. It's completed by the underwriter at the time of issue.

Q. Thank you for the correction. Is there a reason why you would fill out Paul Godlewski in the name category and the policy number and not include the other information?

A. When there are no debits or credits to provide -- by the way, this sheet is automatically

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produced every time an underwriter makes an issue decision. If there's nothing to provide to give him credits, it'll just simply print out with the person's name and policy number.

Q. All right. In other instances, there are sections that are filled out. Does that reflect different information that the underwriter had?

A. That, and not -- this cannot be used on every type of plan. So depending on the plan, it'll appear completed or it won't appear completed at all.

Q. Would this be something you would use on a true term plan?

A. At the time, I believe we did use this on true term, on some of those policies.

Q. What about a VUL?

A. Same.

Q. If you could turn to Tab 12, this is two different pages. It lists a number of lapsed plans and surrendered or other applications.

Do you know if any of these lapsed or surrendered policies included a medical investigation?

A. We can look by looking at the file.

Q. We didn't receive information about the

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surrendered or other applications, and the lapsed plans that did not go back into force we didn't receive any information about at all.

So basically, if he didn't have that plan active at the time, I don't have any information about it, which is why I'm asking you is it possible there would be additional medical information for these lapsed or surrendered plans?

A. Anything is possible.

Q. Would you in the normal course of events conduct an investigation into the plans that are listed here? Can you tell that?

A. We investigate every application that comes in for insurance coverage.

Q. You said that some applications you would perform an additional investigation where you would go to the medical provider. Can you tell from looking at any of the plans that are lapsed or surrendered here whether you would have done that in those cases?

A. Not from this summary, no.

Q. What is the dollar figure that's necessary in order to make that happen?

A. It's not only the dollar figure. It depends on the age and also depends on the

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accumulated or the aggregate amount of coverage that is in force at the time.

So the underwriter here was trying to distinguish which cases she needed to be concerned about that were in force and which cases were not in force that she did not need to be concerned about when coming up with that aggregate level in order to identify requirements.

Q. Looking at Godlewski 1968, which is the second page of Tab 12, I note that on the final surrendered or other application, there's a notation that says dollar symbol 3X2 driving record. What does 3X2 mean?

A. So this policy that was -- you said 1968?

Q. Bates numbered 1968.

A. Okay. Got you. So policy ending in 691 was a term plan, ten years, face amount was 1.4 million. The policy was written on or about June of 2006. It was issued at standard nontobacco rates. And he was charged an extra premium of $3 per thousand to face amount for a period of two years based on his driving record.

I do know from memory, which I do recall, that it was based on speeding tickets and I think driving while suspended. That policy was never

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placed. In other words, he did not accept the policy.

Q. Why would the other policies not include that additional premium?

A. Because when we rate a motor vehicle record, it's based on time and place. If your application comes in and the speeding ticket is now -- let me back up.

We have a chart. And the chart shows us that, depending on the incidents, the type of incidents, and date of occurrence as opposed to today's date whether or not that person is still at risk or in a risk period for either reoccurrence, et cetera. So if additional applications that come in and they were past the period of time where it would be rated and we are no longer concerned about an older speeding record, then they would not have that rating.

Q. How long a period is that?

A. This one was added for a period of two years. So that would have been two years from June of 2006 until -- again, we would have to get the exact date from the policy, which is not here.

Q. Well, I don't have the policy. So I can't help you with that.

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A. Okay. I can tell you that it was added for that policy for that period of time. And at the end of two years, it automatically falls off.

Q. And it looks like there was a policy that lapsed where there is no notation about the dollar figure 3X2. The policy seems to have lapsed in -- it was applied for in 12 of 2006. So why does 6 of 2006 have the additional money for the driving record but 12 of 2006 doesn't?

A. Because December of 2006 is six months later. So it was probably outside of the range to be rated.

Q. I may have misunderstood you. I thought it was two years from June.

A. No. That was for that policy, that period of time.

Q. Understood. If you could turn to Tab 13, these are answers to interrogatories that Lincoln Benefit provided. If you could turn to Page 3, this is a response to my question asking for every material misrepresentation or omission that's on the application.

And the first one that's listed is Godlewski was hospitalized at the Robert Wood Johnson University Hospital in 2012.

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What is it about that hospitalization that would have changed his life rating?

A. It would not have changed his life rating. We would not have issued him a policy.

Q. Why would you have not issued him a policy?

A. Because the reason that he had been admitted to the hospital for two reasons. One is that he had overdosed on prescription medication and it had been mixed with alcohol.

Q. What makes you say that?

A. It's in the record. Is that record here?

Q. It is at a later page. There's a report that he went into the hospital for that purpose. His blood content when it was taken doesn't reflect either of those things.

Would he have an appeals process? Could he have tried to convince you that that was not the real reason he was entered into the hospital?

A. We would have deferred to the medical facility that recorded it because they are licensed. They are the professionals that put this to paper.

Q. If there is a diagnosis that that's what he was there for, that makes sense to me. If there's a note in the file that just says that's

what he's here for, is that it? Case closed, you're done if you see a note in the file?

A. A single note or multiple notes?

Q. Either.

A. Multiple notes for sure, yeah. Even a single note. If it says that's why he's here, that's their assessment and observation. That's what we're going with.

Q. Where is it in the Swiss Re manual or any other manual that says that if you are treated for an overdose you just don't get coverage?

A. We can go back to that other book.

Q. And we can mark the record as confidential from here.

(Whereupon, start of confidential portion of transcript.)

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(Whereupon, start of confidential portion of transcript.)

THE WITNESS: So there's two things that we need to be concerned about. One was his alcohol usage and the drug usage. Even though they are prescription drugs, he had used them in a manner that they were not prescribed. And by mixing them, he ended up with a health impact.

So we will start with alcohol abuse. You should be on 5546.

BY MR. LARKIN:

Q. Yes.

A. So this is the cover page for alcohol abuse life ratings. If you go to the next page, we are going to go to no history of treatment, no history of dependence or addiction, because we don't know that to be the full -- well, this is hindsight. So we are just basing this just on this one record, right?

Q. Sure.

A. So based on the fact that he had had drug usage -- I'm sorry -- alcohol usage with drug usage, he would be considered declined.

Q. I am just looking for where that is.

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A. I am just getting there. I'm sorry. There's a couple of sections here. Let's see what is the best way to get you there.

On 5548, he would be listed as an untreated person. I think at the time of his discharge, they did recommend that he go to rehab. Actually, I would be much more comfortable if I had the records in front of me, but you don't have those here.

Q. I am trying to figure out what it is in this guideline that makes him a decline. And you are saying that on Page 5548, because he is untreated, it looks like that requires that he have either an alcohol dependence or an addiction and alcoholism. Because I am untreated right now.

A. Yeah. So let's not get too ahead of ourselves. I won't say anything until I can provide it to you. I will walk you there.

So we have alcohol dependence or addiction, alcoholism, untreated, less than two years would be a postpone. And that's on 5548. I just want to add to that the drugs also.

Q. That makes sense, but I want to be clear. This presumes that he has alcohol dependence or addiction or alcoholism?

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A. Right, based on what the record reflected.

Q. And bear in mind there's a difference of opinion as to whether he was an alcoholic. So it sounds as if what you're saying is if, in fact, he was not an alcoholic, then that particular section of the guidelines would not apply. But it's your contention that he is?

MR. GOSSELIN: Objection. You can answer.

THE WITNESS: We don't make the diagnosis. What we do is that we look at the records and see what they say. And if the physician says that this is the reason the person is here, these are all the observations over the three or four days that he's in the hospital, this is input that they have, this is a recommendation that they have made, then that's what we go by.

We are not diagnosticians and we don't attempt to make the diagnosis. We just base it on what is written in the record.

BY MR. LARKIN:

Q. So you're telling me it's your recollection that there's a diagnosis of alcoholism, alcohol dependence, or alcohol addiction for Paul

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Godlewski?

A. I didn't say that, no.

Q. The section of the guidelines that you are pointing me to looks like they only apply in that case.

A. Well, let me finish answering your question for the whole section of this. But I would also like to request that medical record about his hospitalization so that we are talking about it at the same time that we are reviewing it.

Q. Okay. I just want to know right now what it is in this guideline that, based on the description you have given me, he overdosed on a mixture of prescription medication and alcohol.

A. Right.

Q. Where is it in these guidelines that as a result of that -- these are your responses to interrogatories.

A. Right. So as an underwriter, I look at the history and I say I have a person who has alcohol usage mixed with prescription medication. Based on that, I'm going to postpone him for a period of two years.

We have drug and alcohol abuse treated concurrently. There are additional factors.

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History of mood disorder, stress, or adjustment disorder.

Q. And these are all under the heading alcohol dependence or addiction, alcoholism?

A. Yes. Then we have another section called alcohol abuse that is descriptive of what an underwriter is looking for or looking at when they are evaluating risk, especially when we have symptoms, we have observations, we have assessments, and we are trying to determine what their risk is, what their mortality is. So we have that abuse section.

By way of medication that he was on, that we find out about the history of the anxiety and what have you, we know what medications he took at the time. And we would go to the anxiety in the nervous disorder section and we would look at the combination of alcohol and a nervous disorder.

Q. Is there a table that specifically deals with the combination of alcohol and a nervous disorder?

A. Yes.

Q. Which table is that?

A. So the one that we just looked at. And then under anxiety.

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Q. I don't see anxiety on this table.

A. Are you in the abuse section, alcohol?

Q. I'm in alcohol.

A. Let me just go back there. So 5549, there are other considerations, additional factors, history of mood disorder, stress, or adjustment disorder.

Q. And anxiety is a mood disorder?

A. Yes. Stress disorder. He was also treated for stress.

Q. And this all falls within the category of alcohol dependence or addiction, comma, alcoholism?

A. I think probably it would be more accurate to say that when you look at the body of medical records that we received from Dorfman, from the hospitalization that he had in 2012, the hospitalization in 2013, and also Dr. Linet's records, when you look at all of that body of information, we have a very clear picture of a person who has an alcohol use problem.

We would probably put him under alcohol abuse in order to rate him.

And then in combination with these nervous disorders, the fact that his nervous disorder had never been completely stabilized, there's a

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consideration about that just by itself that he has a condition that has not yet been stabilized. They keep changing the medication. They keep increasing the medication.

And then there's a situation where he takes it into his own hands to say I'm going to use alcohol and my prescription medications to self-treat myself.

All of that is an abusive profile. And that's where we would say that, no, we would not issue someone who had this history. So you have to look at each section of these and piece together the profile of the individual and what our mortality manual says.

Q. A moment ago you said you were not diagnosticians.

A. Right. We're not.

Q. Now it sounds like you're saying you would look at the picture holistically and you would make your own evaluation of whether there was alcohol abuse?

A. No. What we do is that we use our rating tables that closely fit the situation or the details and the facts that we have been provided.

Q. The next number is No. 2 which is the

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psychiatry unit at Robert Wood Johnson University recommended Godlewski seek outpatient treatment at the Princeton House Behavioral Health after he was discharged.

Are you automatically bumped out of coverage if you're recommended for outpatient treatment?

A. Yes. And depending on the time. So in this case, again, you have to look at the fact that we are dealing with someone who has both alcohol and prescription drug abuse that has ended up in an emergency situation, a health concern situation. He was actually injured during this period of time.

So if he's referred to a psychiatrist for further evaluation and treatment or counseling, we would postpone that. We would not make a decision -- I'm sorry -- we would make a decision. We would decline the coverage until some later point in the future when everything had stabilized. He was not stable at the time.

When he was discharged, he was told to go and seek, you know, psychiatric help.

Q. What does stable mean to you?

A. Stable for the purposes of underwriting is someone who has a condition and that condition has

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been brought under control so the person can function.

Q. He was going to work every day. He was interacting with people every day. He was, by at least some definitions, I suppose, functioning. Seems like he was criminal most of the time so I guess maybe not.

What do you have to do in order to function?

A. You know, you look at the doctor's records. I think Dr. Dorfman probably provided the best profile of him. He met with him at one point every month and then it went to, like, every two months, I think, just before he died.

But he was -- he would be in one visit and the doctor would -- he was very abbreviated in his notes but he would write stable. Then the next month he would come in and extremely high stressors. Medication had to be adjusted again. He was having not only family problems; he was having financial problems. His insomnia was also an issue based on his unstable day-to-day existence.

Q. Is insomnia something that Lincoln Benefit didn't know about at the time of the applications?

A. No, we did not.

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Q. If you received medical records about insomnia and about Paul being treated with Ambien, that would come as a surprise to you?

A. Yes.

Q. Dr. Dorfman called the anxiety mild to moderate, and he said that the level of prescription medications that Paul was taking was not out of his standard range.

Would that change your testimony at all?

A. No.

Q. With respect to a number of these other numbers, it seems to me like a similar mixture of alcohol and drugs. Do I understand that's your consistent concern, the mixture of alcohol and drugs?

A. That's the primary concern.

Q. I don't imagine you love the head injuries.

A. Well, there are a number of concerns. One is he had -- since 2009 on, he was having issues. And he sought treatment from multiple doctors. At the same time that he was seeing these doctors, he was filling out applications. And although he provided the doctors -- some doctors with his medical history, he never reflected any of that on

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our application.

So the fact that these were long-term issues that had not yet been stabilized -- particularly the anxiety, panic disorder, insomnia, the fact that he was on multiple medications to attempt to control it and that still was not controlling it, that's one issue.

The other issue is that he was going to another doctor unbeknownst to the first one and receiving additional medication.

He had head injuries. At one point he says that he had eight head injuries. I think we see four in the records. At least we can trace four in the records that we received upon investigation where he was concerned about the residuals. We never received that.

There's one note in one file in the medical records that we received during underwriting where there was an old history of loss of consciousness but there was nothing that indicated that he was having any continuing problems or there was any after effect.

So we were not aware of any of this information. I think probably the most important history that would have led us to not issue nor

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reinstate these policies was the combination of the anxiety history, the nervous disorder history, the level of medication that he was taking, the fact that he was abusing these prescription drugs in addition to using alcohol at the same time; and there had been three recorded incidents of where these things led to an emergency room or hospitalization.

These are significant facts. We would not have issued these. No one would have issued these.

Q. You note at No. 9 Godlewski frequently traveled outside the United States. My understanding from your earlier testimony is that that is no longer a concern that you have.

A. That is correct.

Q. Based on the countries you are aware of?

A. Assuming that we know all at this point.

Q. I assume that if tomorrow we discovered that he's been spending a lot of time in South Sudan, that could change. But as of right now.

In 10, you say Godlewski was an avid SCUBA diver. What makes you say that he was an avid SCUBA diver?

A. I think at the time we received, during the early part of the investigation, it appeared

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that he was a SCUBA diver.
Q. Does it appear that way now?
A. We don't have sufficient information to say that. There are indicators, but we don't have sufficient information. We don't have, for example, a copy of a PADI book, a diver's book, guide.
But maybe I should say if he was a SCUBA diver, this would have been a severe concern because anybody who has that level of medication that they are taking, the benzodiazepines, in addition to his history of using these substances, we would not have issued that.
Q. Sure. Makes sense. It sounds like right now you're saying -- again, this is all subject. We are not done with fact discovery. You are just not aware that he was a SCUBA diver? You don't have evidence of that?
A. We don't have evidence. There is some indication that he was, but we have not found that as far as I know.
MR. GOSSELIN: We are waiting on the subpoena from the Diver's Action Network. You guys got a copy of that. The lawyer called me yesterday and he was going to have those records for us within two weeks.

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MR. LARKIN: Should we take a break?
MR. GOSSELIN: Why don't we? It's been over an hour.
(Whereupon, a brief recess was taken.)
MR. LARKIN: Back on the record.
THE WITNESS: I just wanted to make an addendum. I thought it might be helpful because you were asking to quantify what's in the records, which I don't have in front of me, to point out all those indicators that are in the record that reflect the evaluation of the doctor and all the input that had been placed in the record.
But as an underwriter, when we are evaluating alcohol use, not everybody is diagnosed with alcohol abuse, dependency, alcoholism, et cetera. This is on your 5551 page.
When we are defining alcohol abuse, what we are looking for in the record, as I said, we are not diagnosticians but we've got to go with the facts presented.
One of the first things that you have listed out of the four types of alcohol

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disorders, there's alcohol use, alcohol abuse, alcohol dependence, or alcoholism and then binge drinking.
So for the very first one, alcohol use disorders include abuse and dependence and they are present when the consumption of alcohol and resulting intoxication interferes with an individual's ability to maintain control over his or her actions, especially those that promote personal health and safety.
If you read this entire section, the types of things that we are looking for is to find out whether or not we have a person who has an alcohol problem based on the fact that they were hospitalized or there was a medical intervention because of it.
Now, is that treatment? I can't really say. We are not talking about Alcoholics Anonymous or he's been put on anti-abuse or what have you. But we do know that he ended up in the hospital because of use of prescription drugs and alcohol.
So as I said, when you look at the entire body of records that we received, all the indicators show that this is the type of

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profile that we had.
BY MR. LARKIN:
Q. I guess what I'm struggling with is you've said a couple of times now that you're not diagnosticians. And then it sounds to me like you're saying but we're going to evaluate the facts and make a decision whether he suffers from one of a number of different medical disorders, which sounds to me a lot like being a diagnostician.
A. No. It's using a reference in our manual that best addresses the facts that we have been presented with.
Q. So in the case of a person who had no diagnosis of alcoholism, alcohol dependence, binge drinking, or problem drinking, you would be comfortable making the decision, although no doctor has said that he has one of those problems, we're going to decide that he does and put him in one of the spots in the --
A. No. What we're going to say is if the facts show that he was drinking, there was an effect from that drinking -- they smelled alcohol on him, I think, when he was admitted to the hospital. I'm not sure if that was that record. I'm pretty sure it was that record. It might have been the Turks

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and Caicos one.
But he had been hospitalized a number of times and alcohol was part of the issue.
So as I said, a lot of the information that we have are based on statistics of known histories. But not everybody fits exactly into every category with their profiles. And sometimes you don't have a diagnosis.
But facts are facts. If they are telling you that he is here, all of the conversations about alcohol use, overuse, and its effect are in his record, then we have to decide, well, where are we going to put him in order to determine what his mortality is.
Q. And you're saying that you would put him into the alcohol abuse category?
A. Right.
Q. I guess that really kind of answers Question No. 13. You put down: Godlewski suffered from alcoholism. It sounds like that's why you believe he suffered from alcoholism.
A. Right.
Q. So there's not a diagnosis that says he suffered from alcoholism, but you have reviewed the incidents and there are three, maybe four times he

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was sent to the hospital for alcohol-related injuries.
A. Alcohol was a component of each one of these, yes.
Q. And four incidents to you creates alcoholism?
A. I didn't say it's alcoholism. But I'm going to use that as a reference to try to assess the risk that he presents.
Q. Well, you did say it was alcoholism. Not you personally, but Lincoln Benefit did. Because at No. 13, the answer to my question, give me every material misstatement or omission, it says Godlewski suffered from alcoholism.
My question now is a little different from what we were talking about before. I'm asking four incidents constitutes alcoholism, it sounds like?
A. I'm not sure how you got there. But alcoholism can be diagnosed in one incident. I am just saying that when I'm looking at records that show a consistent usage of alcohol as being a part of his health issue, then we know that we have an alcohol component.
Q. Okay. And that's alcoholism? Because you're very carefully not using the word

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"alcoholism." You have said alcohol component, alcohol problem, drinking problem.
A. Well, maybe to make it clear, whether we use alcohol abuse, alcoholism, the facts are the same. He has an alcohol problem. Which one of these problems it is? It may be abuse. It may be alcoholism.
I think at one point there is a mention in there, but I think it came from a family member. Actually his father and maybe one of his girlfriends. So there is an indicator that there is a problem and it has been observed.
Q. You keep saying a problem, but it says right here Godlewski suffered from alcoholism. What is it that specifically makes it alcoholism in this case?
A. The fact that alcohol was a component in his health disorders that put him in the hospital.
Q. And then the next one is Godlewski suffered from an opioid addiction. What makes it an opioid addiction?
A. These are words that -- this was a diagnosis that came in a record from Dr. Linet.
Q. There's no one else who has indicated that Godlewski suffers from an opioid addiction.

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Dr. Linet was pretty confident that he heard that from Paul Godlewski. I want to make real sure that I understand that is the extent for the basis of that claim. It's Dr. Linet?
A. He's a licensed professional and those are his official records.
Q. Absolutely. I understand. I just want to make sure there's not something else out there that I missed.
A. (Witness shakes head.)
Q. You're shaking your head no.
A. When you say there's not something else you missed, by way of what records we have? Is that what you're saying?
Q. Yes.
A. You have all the records that we have.
Q. We thought that yesterday and then another 900 pages showed up. So I'm a little leery of saying that I agree with you. That's why I'm pressing you on this issue and will on a few others.
A. Okay.
Q. The next one, I asked: Tell me the effect that each one of the misrepresentations would have had individually. And the response is: Each misrepresentation or omission must be analyzed

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collectively with the entirety of the truthful information concerning Godlewski.

You have identified a number of individual problems, however, that just all by themselves would have disqualified Godlewski from insurance. So why are we analyzing them collectively?

A. Because it's the collective co-morbidities that make a difference. So you're asking -- before you said you had anxiety. Are you uninsurable? No, you're not. But depending on the severity of your anxiety or the multitude of medications that have to be dispensed in order to control it, if it can be controlled, that makes a difference.

Now, in relation to anxiety or any other nervous disorder, he had a couple of them. If they are not controlled, that's a big issue. If, in addition to those mental disorders, now you're adding substance abuse, that is a huge issue because the mortality of that combination is excessive. It's uninsurable.

Q. What are the mental disorders that he suffered from?

A. So he had panic disorder. He had extremely high stress. He had depression. He had high anxiety, uncontrolled high anxiety. He had a

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compulsive disorder.

Q. Who diagnosed him with the compulsive disorder?

A. There are a multitude of records here. I was really hoping that you would have the records so we could just open them up and point to it.

Q. I will tell you Dr. Linet told us that he had panic disorder and Dr. Dorfman told us that he suffered from insomnia and --

A. I'm sorry. In addition there was insomnia, yes.

Q. Which you said you didn't have any records of beforehand.

A. Right.

Q. And Dr. Dorfman also said that he suffered from mild to moderate anxiety. Dr. Dorfman called it severe panic disorder.

I have not heard from a medical professional that he suffered from a compulsive disorder. I have not heard from a medical professional that he suffered from a specific stress disorder. And your testimony is there's a record somewhere separate from the deposition testimony that we received that indicates that he does.

A. You know, I hate to do this from memory,

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but I believe that the depression is listed in the hospital that begins with an H. I will back up.

There is a mention of depression. There is a mention at least twice of a compulsive disorder. I think once it says it's OCD and another doctor -- I think it was Linet -- says something about he makes a lot of lists. He's compulsive in that way.

But there's depression listed. It was during a hospitalization. It's listed multiple times.

Q. On Page 7, I asked what the value of the premiums that had been accepted were. And the answer was: We don't know yet but we will find out.

Do you know what that value is yet?

A. Is that the -- well, I can tell you that the value of the premiums represented the amount of insurance that he had to -- or the premium that he had to pay based on his categorization. Most of his policies were issued at standard nontobacco rates.

Q. My question though is: Do you know how much he paid in premiums all together?

A. Oh, I cannot tell you. That's what you meant by total value of premiums? The actual dollar amount?

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Q. The actual dollar amount.

MR. GOSSELIN: That's something that can be gotten easily.

THE WITNESS: Yeah. That can be easily found out.

MR. LARKIN: That's what I thought. I was surprised it wasn't there, but we will get to it. It's not the biggest thing.

BY MR. LARKIN:

Q. If you could go to Tab A, there's a lot of repetition in here. So I'm hoping we can move through these a little faster as we go through them.

If you could go to Page 8 in Tab A.

A. (Witness complies with request.)

Q. I have asked a couple of questions about Godlewski's suicide. And the answer to all of them has really been you have to direct this to our expert.

I understand that you're not going to be able to give me medical information about the effects that drugs would have on the body or anything else. But my question is can you tell me how he committed suicide.

A. Can I tell you how he committed suicide?

Q. Yes.

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A. I wasn't present.
Q. Okay.
A. I can tell you what the historic record shows of multiple incidents that seem to be reflective or exact in profile to how he may have died from at least the indications that -- some of the indications that we see.
And that is that he combined prescription drugs with alcohol; and then usually he was in a place where it probably was not the best place to be. One time he was in a hot tub. One time he was snorkeling.
Q. So it sounds to me like you're saying it happened before and that's what we think happened this time? And I will kind of expand a little bit just to be clear.
You've told me what you think or at least I can infer what you think is the reason he would commit suicide. So I understand that. I certainly see that he has a history of contemplating suicide in the recent days or weeks before he died based on the web searches he was conducting.
But there's a medical professional who has testified he died of a heart attack. So my question is: I can see why he might have committed suicide,

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but what is it that makes you say that he did commit suicide?
MR. GOSSELIN: I object. You can answer the question. But this is a question that really only an expert -- we would have to rely or likely have to rely on an expert for this.
But she can answer the question. I think she just did. But if there's more you want, that's fine.
BY MR. LARKIN:
Q. If there's a gun found next to the body and there's a hole in the man's head and a note that says goodbye, cruel world, I know the facts are going to say we think we know how he committed suicide.
Do you have a contention that he took medication in this case to cause his own death?
A. All I know is that he was in a habit of taking excessive amounts of prescription drugs. It's in the record every time he took more than he was supposed to take. He was warned over and over again not to take too many and not to mix it with alcohol. And in the record, it says that he intentionally took both together.

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Q. And your contention is that occurred --
A. My contention is that is a dangerous situation.
Q. And that occurred before his death, immediately prior to his death?
A. I am just talking about the incidents that we have records of. The primary reason we would not have issued him is because he could have died from these incidents.
Q. Is it your contention that he did die from the incidents?
A. No. What I'm saying is that in the record, there is a history of this happening.
Q. See, because there are two claims. One is material misrepresentation and the other is suicide. I have to win on both in order to win the case.
So I'm trying to figure out separate from material misrepresentation what is it that makes you think that he actually committed suicide as opposed to he was a suicide risk.
It sounds like what you're telling me is he had means, motive, and opportunity. But that's not the same as saying here is how I know he actually committed suicide.
A. I am just saying that there are three

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incidents, and I have never seen this before where the same situation has happened and the person nearly died. Three separate incidents in a very short period of time. Each one of them were based on the same combination of factors.
Q. Moving to the next tab which is B, if you could go to Page 2, there was a change in premium on a number of the policies from standard nonsmoker, Table B, to just standard nonsmoker. Why the change?
A. So years ago -- I'm sorry. Unless you have the name of the physician -- I don't have it by memory -- one of his physicians had seen spots on his back and his neck. It turned out he had dysplastic nevus. He had some keratosis. He had what we might call skin tags. But they were growths, benign tumors. And he had them removed.
But he had a number of them removed. I think he had six or seven of them. But because of the recurrence and the pathology reports, our rating manual indicated that we needed to put a table rating on it.
So when I was talking about debits before, debits translate into table ratings, categories. So we rated him at 50 percent increase in mortality

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because of those nevus -- because of that nevus history.

Apparently he no longer had any further concerns and we removed the table rating. So we gave him a standard nontobacco rating.

MR. HAYDEN: Did you say you removed the table rating?

THE WITNESS: Yes.

MR. HAYDEN: Thank you.

BY MR. LARKIN:

Q. That's the same as Table 2? Table B is Table 2?

A. Yes.

Q. Go then to Tab C, Page 2. This is essentially the same question. The table rating, I'm assuming, for all of the policies was removed for the same reason?

A. Yeah. This started back in 2006 with one of the very early policies.

Q. How long do you have to go with no concerns before the table rating can be removed?

A. Depends on the condition.

Q. For this condition?

A. So since he no longer had any of these and also -- well, because he no longer had any of these,

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we felt that we were comfortable giving him a standard rating.

Q. So there's no waiting period?

A. Yeah. There's always a waiting period.

Q. How long was the waiting period?

A. So I think the last one he may have had removed was in 2009. It was either 2007 or 2009. After that, everything else that he had removed was of no importance.

Because there was no recurrence, he no longer needed the rating for that condition because it was no longer present. It had been a while ago. There was no recurrence.

We do that with any tumor, whether it's breast cancer, prostate cancer, whatever. When was it removed? Has there been a recurrence? How long has it been? If the time from incident to present evaluation time lengthens, then that rating will either go down to nothing or it could just simply be removed.

Q. From my reading, it looked like the dysplastic nevi would cause you to have the Table B but the basal cell carcinomas would not; is that correct?

A. Right.

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Q. The basal cell carcinomas that were being removed, those are what you were referring to as not having any importance?

A. Well, they do have in combination with the presentation of nevus, yes. Whenever you have cellular activity, there is a concern.

So between the two of them -- I think they were both from 2005. If we had the record, I would be able to pinpoint the date. Because there had never been a recurrence, we were comfortable with going standard. We do that with all of our customers.

Q. If you could look at Page 9, my question is: If you contend Godlewski suffered from an anxiety disorder, set forth the risk classification of that disorder as the term is used by the Swiss Re manual.

And the answer was --

A. Sorry. What page?

Q. Page 9. The answer was: You should talk to Swiss Re about that.

A. Are you talking about under 15, the last line?

Q. Yes.

A. Tell me again please.

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Q. My question to you is: What is the risk classification that you would give to Paul's anxiety?

A. Oh. So that's in the documents that we gave you, that we provided that we were just looking at a minute ago.

Q. That sets forth all of the various risk classifications. My question is: What is your contention -- was it in this case? What is the risk classification in this case?

A. So in the doctor's reports, based on the doctor's reports, based on the inability of the doctor to control the anxiety, in addition to the combination of the alcohol being present and the abuse of the medication itself, that would have been not a rating. It would have been a decline. We would not have issued him a policy.

Q. When I use the term "rating" -- and that's perhaps an error -- I understand it to be mild, moderate, or severe. And based on within those categories, it would then be an additional fee that you pay, monthly premium, or a decline or a postpone.

So my question is: It sounds like you're saying it would be severe anxiety?

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A. When it's uncontrolled, sure, yes.
Q. What makes something uncontrolled?
A. So a number of things. The fact that the medication that's been prescribed is not resolving the issue. Additional medication is not resolving the issue. An increase in medication is not resolving the issue. The doctor reflects that the stress continues, that the patient needs to be moved to some additional medication. That's not controlled.
Q. Dr. Dorfman testified that it's rare that you see the issues that his patients come in for being resolved. You don't go in, get fixed, and then move on with your life.
So what would you want to see from someone who had anxiety disorder in order to determine that the disorder was mild?
A. Well, actually, our manual provides -- if you look at 05570 -- actually, I mean, we can read the entire document about what anxiety is and description, et cetera, since you asked about mild, moderate, or severe.
So this particular page, 5571, explains what we would categorize in order for rating purposes mild, moderate, or severe.

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Q. Has Paul been referred for specialist psychoanalysis, counseling, or psychiatric treatment?
A. Dorfman, yeah. And also when he was discharged, he was referred -- it said that there was also supposed to be a psych evaluation in 2012.
Q. What's the difference between a recommendation and a referral to you?
A. Same difference.
Q. You are aware that medically they are not the same thing, correct?
A. Well, it's a verb. I'm referring you or I'm recommending that you go there.
Q. So you understand them to mean the same things?
A. For our purposes, it means the same thing. In other words, the doctor has indicated that there needs to be a second step.
Q. Are you aware if Paul ever took time off work as a result of his anxiety?
A. You know, in the record, it indicates that he has been having problems with -- at work. I wouldn't be able to -- I don't memorize the terminology that he used.
But when he went into Dr. Dorfman, usually

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the very first part of it would be subjective analysis where he is telling Dr. Dorfman how he feels, what's happening in his life. And it appeared that the stresses that he was undergoing were affecting his work.
Q. So you think that he took time off work?
A. Well, I can't tell you whether or not he took time off work. I mean, his occupation -- I'm not sure if he had a 9:00 to 5:00.
Q. What would you call a disabling attack?
A. Well, a disabling attack would be a number of things. One is that it could be not working, not being part of society. It can be hospitalization. It can be inability to function, whether it's socially, whether it's familial, whether it's occupational.
Q. Are you aware if Paul was ever sent to inpatient counseling?
A. Well, he was hospitalized. That was treatment.
Q. Under severe -- I think you understand that I'm asking about these specific definitions of mild, moderate, and severe -- it indicates a severe condition consists of recurring or deeper anxiety for which inpatient care may have been necessary.

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Are you saying that the inpatient care that he received was specifically for the recurring or deeper anxiety?
A. So it's my understanding that the reason that he self-medicated was because of a lot of the stress that he was under and he wanted to relax. So he took the alcohol. He increased his dosage of the Lorazepam. Because of that, he ended up in the hospital.
So he was being treated because the underlying condition that started all of this was the stress that he was undergoing, which is part of that whole anxiety, panic, et cetera. But it was a nervous disorder that caused it, and that's how he ended up in the hospital.
And while he was in the hospital, he, obviously, was disabled because he couldn't do anything else but be in the hospital.
Q. Okay. If you go to 17 on the next page, the final sentence is: Lincoln Benefit responds that Godlewski's mental functional capacity may have been impaired with respect to the following nonexhaustive functions.
A. I'm sorry. I need to catch up with you.
MR. LARKIN: And we can go off

confidential now.

(Whereupon, end of confidential portion of transcript.)